Public Employees Benefits Board (PEBB)

A

PEBB-Sponsored Retiree Coverage Election Form

- **List all eligible family members you wish to enroll on this form**
- **If deferring PEBB retiree coverage, complete sections 1 and 9.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if applicable.

Retiree or employee information ONLY	Retiree or employee name	Retirement system
	Retiree or employee social security number	Retirement date (mm/dd/yyyy)
For K-12 school district retirees only	School district	When does your current **school district** medical/dental **coverage end?** (mm/dd/yyyy)
Re-enrollment after deferment	Date other coverage ended (mm/dd/yyyy)	

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ☐M ☐F
Address	Apt./Unit number	City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)	

The medical plans marked with an asterisk* in Section 5 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for the code.**

Physician or clinic code

Election

Medical Coverage

☐ Enroll: ☐ Medical only ☐ Medical and dental

☐ Defer (due to enrollment in employer coverage) **If deferring, see Section 9. Note: This defers coverage for all family members.**

☐ Defer (due to enrollment in a federal retiree program)

☐ Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.

Date you want coverage to end_____

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ☐ Yes ☐ No If yes, effective date_____

Part B (medical) ☐ Yes ☐ No If yes, effective date_____

If yes, attach a copy of your Medicare card to this election form.

Are you receiving Medicare disability? ☐ Yes ☐ No If yes, effective date _____

If yes, attach a copy of your Social Security Disability Award letter.

(continued on next page)

Section 2: Spouse or Same-Sex Domestic Partner

List only family members you wish to cover; family members cannot be enrolled in any other PEBB coverage.

Relationship to subscriber If adding a spouse or partner, please attach a completed *Declaration of Marriage or Same-Sex Domestic Partnership* form.

☐ **Spouse:** date of marriage_____ ☐ **Same-sex domestic partner:** date criteria met _____

Social security number	Last name	First name	Middle initial	Sex ☐M ☐F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	Physician or clinic code

Notice of Qualifying Event (see below)

Medical Coverage ☐ Enroll ☐ Waive

☐ Terminate Reason: ☐ Widowed ☐ Divorce ☐ Legally separated ☐ Dissolution of same-sex domestic partnership

Date of qualifying event _____

Are you enrolled in Part(s) A and/or B of Medicare? **Part A (hospital)** ☐ Yes ☐ No If yes, effective date_____

Part B (medical) ☐ Yes ☐ No If yes, effective date_____

If yes, attach a copy of your Medicare card to this election form.

Are you receiving Medicare disability? ☐ Yes ☐ No If yes, effective date _____

If yes, attach a copy of your Social Security Disability Award letter.

Section 3: Family Member Information (such as a child, grandchild, etc.) ***Use additional forms for more members.***

1

Relationship	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyyy)	Sex ☐M ☐F	☐Disabled? ☐Student? *Check only if age 20 or older.*	Physician or clinic code

Address (if different from subscriber)	City	State	ZIP Code

Notice of Qualifying Event (see below)

Medical Coverage ☐ Enroll ☐ Waive ☐ Terminate

Reason:

☐ Loss of student status ☐ Married ☐ Other (explain) _____

☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership

☐ Attained age that is no longer eligible for PEBB coverage

Date of qualifying event_____

Are you enrolled in Part(s) A and/or B of Medicare? **Part A (hospital)** ☐ Yes ☐ No If yes, effective date_____

Part B (medical) ☐ Yes ☐ No If yes, effective date_____

If yes, attach a copy of your Medicare card to this election form.

Are you receiving Medicare disability? ☐ Yes ☐ No If yes, effective date _____

If yes, attach a copy of your Social Security Disability Award letter.

(continued on next page)

Section 3: Family Member Information continued (such as a child, grandchild, etc.) *Use additional forms for more members.*

2

Relationship	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex	Disabled? Student?	Physician or clinic code
		☐ M ☐ F	*Check only if age 20 or older.*	

Address (if different from subscriber)	City	State	ZIP Code

Notice of Qualifying Event (see below)

Medical Coverage ☐ Enroll ☐ Waive ☐ Terminate

Reason:
☐ Loss of student status ☐ Married ☐ Other (explain) _____
☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership
☐ Attained age that is no longer eligible for PEBB coverage
Date of qualifying event _____

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ☐ Yes ☐ No If yes, effective date_____

Part B (medical) ☐ Yes ☐ No If yes, effective date_____

If yes, attach a copy of your Medicare card to this election form.

Are you receiving Medicare disability? ☐ Yes ☐ No If yes, effective date _____

If yes, attach a copy of your Social Security Disability Award letter.

Section 4: Additions or Changes *Check all that apply.*

Change: ☐ Name ☐ Address ☐ Medical plan ☐ Dental plan

Change in family status:

☐ **Adding a spouse or qualified same-sex domestic partner**
You **must** complete a *Spouse or Same-Sex Domestic Partner Certification* form, available from the Health Care Authority or online at **www.pebb.hca.wa.gov**

☐ **Adding family member 1** (from Section 3) ☐ **Adding family member 2** (from Section 3)

Section 5: Medical Plan Selection *Check only one.*

☐ Community Health Plan of Washington†
☐ Group Health Cooperative† ‡
☐ Group Health Options, Inc.†
☐ Kaiser Foundation Health Plan of the Northwest ‡
☐ PacifiCare of Washington, Inc.† ‡
☐ Regence BlueShield†
☐ UMP Neighborhood† (Medicare enrollees may not be eligible.)
☐ Uniform Medical Plan PPO
☐ Medicare Supplement Plan E, administered by Premera Blue Cross
☐ Medicare Supplement Plan J (with prescription-drug coverage), administered by Premera Blue Cross **(current members only)**
☐ New Medicare Supplement Plan J (without prescription-drug coverage), administered by Premera Blue Cross

† **These plans require the physician or clinic code of your selected primary care provider. Contact your plan or go to the Provider Directory on our Web site for the code.**

‡ **These plans offer Medicare Advantage plans available only to Medicare enrollees where available. Complete and attach the *Medicare Advantage Plan Election* Form (form C).**

Section 6: Dental Plan Selection *Check only one.*

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services from any provider)

Note: Delta Dental is the parent company of Washington Dental Services (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name or clinic code _____
(must receive services from DeltaCare provider)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from Willamette Dental Group Provider)

☐ **Cancel Dental**
I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB dental plan for at least two years or I am now covered under employer-sponsored dental. If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

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Section 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB employee life insurance. Application for Retiree Term Life Insurance must be made at the time of retirement. The cost is $2.19 per month regardless of age.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ☐ **Yes** ☐ **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Coverage
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

Beneficiary_____ Beneficiary's SSN _____

Relationship to retiree _____ Beneficiary's date of birth _____

Beneficiary's address _____

_____

Section 8: Authorization for Enrollment and/or Premium

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

☐ Yes, deduct from my pension

☐ No, I will send my payment monthly

Note: You must make the first payment before you will be enrolled.

Section 9: Signature *Required*

By submitting this form, I declare to the best of my knowledge and belief that my family members and I are eligible for the coverage requested. I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years. I understand that I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority (HCA) to be ineligible for coverage.

If deferring coverage, I certify and understand the following provisions:

In order to reinstate my PEBB coverage after deferring for employer-sponsored coverage, I must submit an enrollment form and proof of continuous enrollment in employer-sponsored coverage to HCA within 60 days of the date the other coverage ends. My surviving dependents must submit an application to defer or enroll in PEBB retiree coverage within 60 days of my death.

If deferring my PEBB coverage due to enrollment in a federal retirement program, my dependents and I may exercise a one-time re-enrollment in the future. To exercise re-enrollment, my surviving dependents or I must submit an enrollment form and proof of continuous enrollment in a federal-sponsored retiree medical plan to HCA during an annual open enrollment or within 60 days of the date the other coverage ends.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information I submit as public record. The HCA's privacy notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Retiree signature Be sure to sign this form after printing Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Return form to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

Be sure to sign and date this form.

Note: If you or your dependents are entitled to Medicare, you must be enrolled in **Medicare Parts A and B**. If you haven't done so already, please send a copy of the Medicare card(s) along with this form.

Visit our Web site at www.pebb.hca.wa.gov